

Dr. _____ Date _____ Time _____ Patient # _____

PATIENT INFORMATION:

Name _____ Sex: M F Date of Birth: ____/____/____

Address _____
Street City State Zip

Social Security # _____ - _____ - _____ Home Phone _____ Emerg. Phone _____

Employer _____ Employer Phone _____
Use/Interested in contacts? Yes No

Reason for Visit _____

Were you referred to our office by another doctor? No Yes - Dr. _____

PRIMARY INSURANCE INFORMATION:

Street & City?

Insurance Company Name _____

Name of Subscriber _____ Relationship to Patient _____

Date of Birth: ____/____/____ Social Security # _____ - _____ - _____ Employed Yes No

Employer _____ Employer Phone _____

If you have additional insurance, please complete this section:

Insurance Company Name _____

Name of Subscriber _____ Relationship to Patient _____

Date of Birth ____/____/____ Social Security # _____ - _____ - _____ Employed Yes No

Employer _____ Employer Phone _____



Kentucky Eye Institute complies with the FTC "Red Flag" identity theft regulations.

If you are covered by Medicare and a Group Health Insurance, please complete this section. Are you or your spouse still employed? Yes No If yes, does the employer have (check one) 20 or more employees 100 or more employees? Are you entitled to Medicare as a result of a disability? Yes No Are you entitled to Medicare due to renal disease? Yes No

INSURANCE AUTHORIZATION: I request payment of all authorized benefits be made on my behalf to KEI for any services I receive from any KEI doctor. I authorize any holder of medical information about me to release information as needed to determine these benefits or the benefits for related services to my insurance company(ies) and their agent(s), including the Centers for Medicare and Medicaid Services (CMS) if I have Medicare/Medicaid coverage. I understand that I am responsible for all deductibles, co-pays, non-covered services, and the 20% Medicare does not pay (if applicable).

Patient/Responsible Party Signature

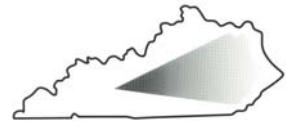
Date

PAST DUE ACCOUNTS: I understand that interest will be charged on accounts that are 90 days or more past due. If KEI turns my account over to a collection agency, I understand that the collection agency will add interest of 1 1/2% per month (18% per year) to any unpaid balance. Except for emergencies, if my account has been turned over for collection, I may only schedule future KEI appointments if I pay: for future services in advance, unpaid balances, and collection agency commissions and/or legal fees paid by KEI to collect my delinquent account.

Patient/Responsible Party Signature

Date

Appointment in Computer Information in Computer ROS & New Patient Sheets Mailed 041009



Kentucky Eye Institute

Please bring the following with you to your appointment:

- **Photo Identification (required).**
- **Enclosed questionnaire** completed with your information.
- Referring doctor's (or family doctor's) name and complete address:

Referring or Family

Doctor's Name: _____

Address: _____

Phone: _____

- Glasses and/or contact lenses, if you wear them.
- Current **insurance** card or cards.
- **Referral**, if needed, from your HMO/primary care physician.
- You may need a **driver** to drive you from your appointment, in the event that your eyes are dilated.

Thank you for your assistance. The information you provide will help us serve you. We look forward to seeing you.

Sincerely,

KENTUCKY EYE INSTITUTE

☺KINDLY GIVE 24 HOURS NOTICE FOR CANCELLATION☺

ALL CO-PAYS, DEDUCTIBLES, AND SELF-PAY AMOUNTS ARE DUE AT THE TIME OF SERVICE.

Master Document

HAVE YOU HAD OR DO YOU HAVE

(Circle "Y" for Yes or "N" for No)

Y	N	(1) decreased far vision	Y	N	(35) diabetes
Y	N	(2) decreased near vision	Y	N	(36) high blood pressure
Y	N	(3) decreased side vision	Y	N	(37) shortness of breath lying flat
Y	N	(4) decreased color vision	Y	N	(38) chest pains
Y	N	(5) poor driving vision (day)	Y	N	(39) rheumatic fever
Y	N	(6) poor driving vision (night)	Y	N	(40) a cold in the past 2 weeks
Y	N	(7) halos around lights	Y	N	(41) unexplained weight loss
Y	N	(8) glare	Y	N	(42) rectal exam within last year
Y	N	(9) poor depth perception	Y	N	(43) mammogram within last year (F)
Y	N	(10) distorted vision	Y	N	(44) pelvic exam within last year (F)
Y	N	(11) difficulty with reading	Y	N	(45) asthma
Y	N	(12) difficulty recognizing people	Y	N	(46) excessive dryness of mouth
Y	N	(13) difficulty watching TV	Y	N	(47) slow pulse rate
Y	N	(14) floaters	Y	N	(48) persistent cough
Y	N	(15) flashing lights	Y	N	(49) ulcer (gastrointestinal)
Y	N	(16) redness of eyes	Y	N	(50) persistent fever
Y	N	(17) itching of eyes	Y	N	(51) difficulty urinating
Y	N	(18) mattering of eyes	Y	N	(52) bleeding problems
Y	N	(19) sensitivity to light	Y	N	(53) cancer
Y	N	(20) double vision	Y	N	(54) immunosuppression
Y	N	(21) previous eye surgery	Y	N	(55) abnormal anesthetic reaction
Y	N	(22) previous eye injury	Y	N	(56) blood thinner/aspirin in last month
Y	N	(23) "crossed eyes"	Y	N	(57) environmental allergies
Y	N	(24) out-turning eyes	Y	N	(58) immunizations NOT up-to-date
Y	N	(25) lazy eye	Y	N	(59) lung (emphysema, TB) problems
Y	N	(26) eyes that bulge	Y	N	(60) kidney / bladder disease
Y	N	(27) retinal disease	Y	N	(61) GI (stomach/bowel) problems
Y	N	(28) macular degeneration	Y	N	(62) extremity problems
Y	N	(29) glaucoma	Y	N	(63) endocrine gland disease
Y	N	(30) dry eyes	Y	N	(64) head, neck, throat problems
Y	N	(31) burning of eyes	Y	N	(65) psychiatric problems
Y	N	(32) skin problems	Y	N	(66) neurological disease
Y	N	(33) ear, nose, mouth, throat disease	Y	N	(67) heart/cardiovascular disease
Y	N	(34) arthritis	Y	N	(68) blood (hepatitis, anemia) disease
			Y	N	(69) reproductive system problem

COMMENTS

☆☆☆TURN OVER TO COMPLETE!!!☆☆☆

Patient Name _____ **Date** _____

IS THERE A FAMILY HISTORY OF:

(circle "Y" if yes and "N" if no)

- Y N (1) cataracts
- Y N (2) diabetes
- Y N (3) glaucoma
- Y N (4) macular degeneration
- Y N (5) other eye disease* _____
- Y N (6) abnormal anesthetic reaction
- Y N (7) other disease* _____

*Please list in space provided

DO YOU HAVE ALLERGIES TO ANY MEDICATIONS?

(circle "Yes" if yes and "No" if no)

YES NO If "yes" list below:

LIST ALL MEDICATIONS YOU TAKE (PRESCRIBED, NON-PRESCRIBED, AND OVER-THE-COUNTER:

Check (✓) here if none _____.

Medicine Name

Condition for Which Medicine is Taken

(1) _____

(2) _____

(3) _____

(4) _____

(5) _____

(6) _____

(7) _____

LIST ANY HOSPITALIZATIONS, OPERATIONS, MAJOR ILLNESSES, AND INJURIES:

Check (✓) here if none _____.

(1) _____

(2) _____

(3) _____

(4) _____

(5) _____

ANSWER EACH:

- (1) How many packs of cigarettes do you smoke per day? 0 1 2 3 More
- (2) How many alcoholic drinks do you drink per week? 0 1 3 5 10 More
- (3) Marital status. Single Married Divorced Widowed Other
- (4) Do you use illegal drugs? Yes No
- (5) Occupation (if retired, state "Retired" and what occupation was). _____
- (6) Number of people who live in your household (including yourself). 1 2 3 4 More

Please list any other information about your health that you think we should know. _____

Family Medical Doctor and Address _____

When did you last see him/her? _____

Reviewed

Date

☆☆☆ **COMPLETE OTHER SIDE!!!** ☆☆☆